Report

of the

Examination of

Health Tradition Health Plan, Inc.

Onalaska, Wisconsin

As of December 31, 2002

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Jorge Gomez, *Commissioner*

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July 31, 2003

Honorable Jorge Gomez
Commissioner of Insurance
Madison, Wisconsin

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

HEALTH TRADITION HEALTH PLAN, INC.
Onalaska, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Health Tradition Health Plan (the HMO) was conducted in 2000 as of December 31, 1999. The current examination covered the intervening period ending December 31, 2002, and included a review of such 2003 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the HMO's operations, and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the HMO
Reinsurance
Financial Statements
Accounts and Records
Data Processing

Emphasis was placed on the audit of those areas of the HMO's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the HMO to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results" contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the HMO's operations is contained in the examination work papers.

The HMO is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

The Health Tradition Health Plan, Inc., is a for-profit group model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as ". . . a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the group model, the HMO contracts with a sponsoring clinic to provide primary and specialist services. HMOs compete with traditional fee-for-service and preferred provider health insurance plans.

Prior to January 1, 2002, the company, formerly known as Greater LaCrosse Health Plan, Inc., was licensed as a life insurance company. The company was incorporated January 16, 1986, and commenced business April 28, 1986. The HMO is a wholly-owned subsidiary of Mayo Group Practices, whose sole member is the Mayo Foundation. The company changed its name to the one currently used on September 24, 2001.

The company provides care to its members through a network of 200 primary care providers and 100 specialty care providers. Since Health Tradition Health Plan, Inc. is primarily a group model HMO, the physicians are retained through contracts with clinics and independent practice associations (IPAs). An IPA is defined by statute as a person, other than a hospital, clinic, or individual physician or other individual health care provider, that does the following:

a) Contracts with a health maintenance organization, limited service health organization or preferred provider plan, as defined in s. 609.01, Wis. Stat., to provide health care services.

b) Provides health care services primarily through health care providers who are independent contractors or who are obligated to provide the services because of membership in the entity.

The company encourages the enrollee to choose a primary care physician. All referrals to specialty care physicians are required to be preauthorized by primary care physicians. Failure to first consult with a primary care physician disqualifies the member from receiving benefits for services provided by the specialty care physician.

The company currently contracts with the following IPAs and clinics:

IPAs	Clinics
Oral & Maxillofacial Surgery Assoc. Of Eau Claire, S.C.	Franciscan Skemp Healthcare, Inc.
Eau Claire Anesthesiologists, Ltd.	Luther Midelfort Clinics
Prairie Medicine	Red Cedar Clinics
Anderson & Durtsche, Ltd.	Wabasha Clinic
Winona Opthamology, Assoc., P.A.	Decorah Clinic
Bruce Davey, MD	Hirsch Clinic
Western WI Urology	Bland Clinic
Family Medicine of Winona	Kickapoo Valley Medical Clinic
Foster Primary Eye Care	Vernon Memorial Outpatient Clinic
Evergreen Surgical, S.C.	Krohn Clinic
Ihle Orthopedic Clinic	LaFarge Medical Clinic
Oral Surgery Clinic of LaCrosse	New Hampton Clinic
Oral & Maxillofacial Surgery Clinic	Rushford Community Clinic
Prosthetic Orthotic Center, Ltd.	Scenic Bluffs Community Health Center
Osseo Optometry Clinic	St. Joseph's Community Health Service
Walsh Optometry Clinic	Viola Health Services Center
Winona Imaging, P.L.L.P.	Winona Clinic, Ltd.
Therapy Associates	Mile Bluff Clinic, LLP
Prosthetic Labs of Rochester	Elroy Family Center
	Nacedah Family Medical Center
	New Lisbon Community Clinic
	Alma Community Clinic
	Plainview Clinic

Franciscan Skemp Healthcare, Inc. (FSHI) is compensated on a capitated-fee-basis. There is a cap of $60,000 on the liability of FSHI for claims incurred by each enrollee per year, with the exception of enrollees in the BadgerCare program, a state sponsored health insurance program for low income families with children. For BadgerCare enrollees, the maximum liability of FSHI is $90,000. Charges for covered services in excess of the capitation liability limit of $60,000 per enrollee, per year, are the responsibility of Health Tradition Health Plan, Inc. This $60,000 limit applies to charges for covered hospital services as well. For all other network clinics, payments to the provider for covered services provided to covered enrollees are at a percentage of submitted charges. For Medicare Select contracts, FSHI agrees to accept Medicare Assignment and the Part B deductible and co-payments allowed for Medicare. Services covered by Health Tradition Health Plan, Inc. that are not covered by Medicare are compensated on the same basis as for commercial enrollees.

At the time of examination, there were 124 primary care providers and 79 specialty care physicians at FSHI. In addition to its contract with FSHI, Health Tradition Health Plan, Inc., had contracts with 76 primary care providers and 21 specialist care physicians.

The contracts include hold-harmless provisions for the protection of policyholders. The agreements have terms of one year, and automatically renew for successive one-year terms, unless terminated upon 90 days' notice by either party.

The HMO contracts with 17 hospitals to provide inpatient services. Participating FSHI system affiliates are reimbursed on a capitation basis for commercial group products and Medicare Select products. Non-FSHI affiliated hospitals are reimbursed (a) on a negotiated per diem and discounted fee-for-service basis for commercial group products and (b) according to Medicare Assignment, including the Part B deductible and co-payments allowed by Medicare for covered services for the Medicare Select Product. Discounted fee-for-service payments to noncapitated providers for hospital services range from 92% to 100% of the usual and customary charges. All provider contracts include hold-harmless provisions for the protection of policyholders.

Contracting hospitals are as follows:

Barron Memorial Medical Center, Barron, WI
Black River Falls Memorial Hospital, Black River Falls, WI
Bloomer Memorial Medical Center, Bloomer, WI
Community Memorial Hospital, Winona, MN
Franciscan Skemp Healthcare, Inc. – Arcadia, La Crosse, and Sparta, WI
Hess Memorial Hospital, Mauston, WI
Luther Midelfort – Eau Claire Campus Medical Center
Methodist Hospital, Rochester, MN
Myrtle Werth Medical Center, Menomonie, WI
Osseo Area Medical Center, Osseo, WI
Prairie du Chien Memorial Hospital, Prairie du Chien, WI
St. Elizabeth's Hospital, Wabasha, MN
St. Joseph's Memorial Hospital, Hillsboro, WI
St. Mary's Hospital, Rochester, MN
Tomah Memorial Hospital, Tomah, WI
Vernon Memorial Hospital, Viroqua, WI
Veteran's Memorial Hospital, Waukon, IA

According to its business plan, the HMO's service area is comprised of the following counties: Buffalo, Crawford, Jackson, La Crosse, Monroe, Trempealeau, Vernon, Grant, Richland, and Juneau.

The HMO offers comprehensive health care coverage which may be changed by riders to include deductibles and copayments. The following basic health care coverages are provided:

Office visits for illness or injury
Inpatient services
Outpatient services
Outpatient diagnostic test
Mental health, drug, and alcohol abuse services
Ambulance services
Emergency services
Maternity services
Breast reconstruction
Reconstructive/cosmetic surgery
Certain dental procedures (injury, periodontal, and oral surgery)
Prosthetic devices and durable medical equipment
Newborn services
Home health care/hospice
Preventive health services
Family planning
Hearing exams
Diabetes treatment
Routine eye examinations
Skilled nursing facility care
Prescription drugs
Cardiac rehabilitation, physical, speech, and/or occupational therapy
Health education
Kidney disease treatment
Second opinion
TMJ/TMD
Urgent care
Weight control/nutrition
Certain transplants
Chiropractic services

Inpatient mental health and AODA coverage is limited to 30 days and $6,300, outpatient mental health and AODA coverage is limited to $900 per year, emergency services have a $25 copayment which is waived upon admission into an inpatient facility, and skilled nursing care is limited to 60 days. Plan coverage is contingent on nonemergency services being provided by participating physicians and hospitals or on the referral of participating physicians. Members are encouraged, but not required, to choose primary care physician from the listing of participating physicians available.

The HMO currently markets to groups and individuals. The plan provides two group insurance products: Premier and Premier Plus. The plan also provides an individual Medicare Select insurance product, 65 Plus. Premier, Premier Plus, and 65 Plus products are marketed by

Health Tradition Health Plan, Inc. through independent brokers. Commissions for individual Medicare Select (65 Plus) is 15% on new business, 11% for the next 4 years and 3% thereafter on renewal business.

The HMO uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the age, sex, occupation, and coverage characteristics for new groups. Experience is reviewed for renewal groups and, based on the review a recommendation is made regarding adjusting the rate or canceling the group. The base rate is adjusted quarterly for inflation and other trending factors.

In addition to the products mentioned above, the company derives approximately 12% of its revenues from Wisconsin Medicaid/BadgerCare Program. The company contracts directly with the Wisconsin Department of Health and Family Services (DHFS), to provide specified healthcare benefits to eligible Medicaid Assistance/BadgerCare recipients. In exchange for these services, the company is paid a monthly capitation rate, which is designed to be less than the cost of providing the same services covered under the contract to a comparable Medicaid population on a fee-for-service basis. Premium rates are specified by the DHFS.

Effective January 1, 1999, the company entered into a contract with UCare Minnesota for the provision of administrative services with respect to the company's Medicaid/BadgerCare program. As compensation for services provided, UCare was paid a fixed per member per month fee for 1999. Under the terms of its contract with DHFS, the HMO remains accountable for any functions and responsibilities that it delegates to its subcontractor.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of nine members appointed by Mayo Group Practices. Pursuant to the amended and restated by-laws, five of the directors represent Minnesota entities, four represent Wisconsin entities. All directors are elected annually to serve a one-year term. Officers are appointed by Mayo Group Practices. The board members currently receive no compensation for serving on the board.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Jasper R. Daube, M.D. Rochester, MN	Mayo Clinic Rochester Medical Director, Dept. of Managed Care	2003
Peter W. Carryer, M.D. Rochester, MN	Mayo Clinic Rochester Chair, Operations for Mayo Health System	2003
David Onsrud, D.O. La Crosse, WI	FSHI Family Practice Physician	2003
Karen L. Ytterberg Rochester, MN	Mayo Clinic Rochester Pediatrician, Community Pediatrics	2003
Joel Rueber Eau Claire, WI	Luther Midelfort Mayo Health System Vice President of Operations	2003
John Nemec La Crescent, MN	FSHI Vice President of Regional Services and Managed Care	2003
Alan R. Schilmoeller Rochester, MN	Mayo Foundation for Medical Education & Research Chair, Mayo Health System Administration	2003
Steve L. Knudson Rochester, MN	Mayo Foundation for Medical Education & Research Director of Finance	2003
Robert Freedland, M.D.	FSHI Ophthalmology Dept. Physician	2003

Officers of the Company

The officers elected or appointed by the board of directors and serving at the time of this examination are as follows:

Name	Office*
Jasper R. Daube	President
David Onsrud, M.D.	Vice President
Mark A. Matthias	Treasurer
Steve L. Knudson	Secretary

* The officers are salaried employees of the affiliated companies, and receive no direct compensation for serving as officers of the company.

Committees of the Board

The company's bylaws allow for the formation of certain committees by the board of directors. The committees at the time of the examination are listed below:

Marketing Committee

Steven M. Kunes, Chair
Alan Krumholz, M.D.
James Berg
Steve L. Knudson
John Nemec
Michael Eckstein

Finance Committee
John Nemec, Chair
Steven M. Kunes
Julie S. Hansen
Mark Matthias
Bruce Plante
Joel Rueber
Greg Fellman
Karen Ytterberg, M.D.

Pharmacy & Therapeutics Committee
Alan Krumholz, M.D., Co-Chair
John Johnson, R.Ph., Co-Chair
Michael O'Brien, M.D.
David Onsrud, D.O.
Dennis McCallum, Pharm. D.

Utilization & Quality Management Committee*

Alan Krumholz, M.D., Chair
David Onsrud, D.O.
Greg Whiteman, M.D.
John Paat, M.D.
Nicole Touchet, M.D.
John Bazley, M.D.
Steven M. Kunes
Beverly Larson
Mary Wanzek
Steve L. Knudson
Jackie Kuhlman

Grievance Committee
Alan Krumholz, M.D., Chair
Steve Kunes

Credentialing Delegation Oversite Committee
Alan Krumholz, M.D., Chair
David Onsrud, D.O.
Greg Whiteman, M.D.
Nicole Touchet, M.D.
Steve Kunes
Ronald Paczkowski
Colleen Bjerke

*The UM/QM committee also serves as the peer review committee.

The company has no employees. Necessary staff is provided through a purchased services agreement with MMSI, Inc. (MMSI), (a wholly-owned subsidiary of Mayo Group Practices) and a management services agreement with FSHI. Under the MMSI agreement, effective January 1, 1999, MMSI agrees to provide underwriting and actuarial services, advise the board, maintain accounting and financial records, provide marketing services, and provide for claims processing and data processing. In exchange for services provided, MMSI receives a fixed per member per month service fee. The term of the agreement is automatically renewed unless terminated by either party upon 60 days' written notice. Services of a medical director, administrative nurses, referral coordinators, and an administrative assistant are furnished through the contract with FHSI effective January 1, 2001, and are charged to HTHP. This agreement shall renew automatically for a one-year term unless terminated by either party upon 60 days' written notice.

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

		Amount Required
1.	Minimum capital or permanent surplus	Either: $750,000, if organized on or after July 1, 1989 or $200,000, if organized prior to July 1, 1989
2.	Compulsory surplus	The greater of $750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3.	Security surplus	The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each $33 million of additional premiums earned in excess of $10 million or 110% of compulsory surplus

4.	Operating funds	Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;

2. One-third of 1% of premium written in this state in the preceding calendar year.

The HMO has satisfied this requirement for 2002 with a deposit of $184,882 with the State Treasurer.

Insolvency Protection for Policyholders

Under s. Ins 9.04 (6), Wis. Adm. Code, HMOs are required to provide continuation of coverage for its enrollees. These requirements are the following:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

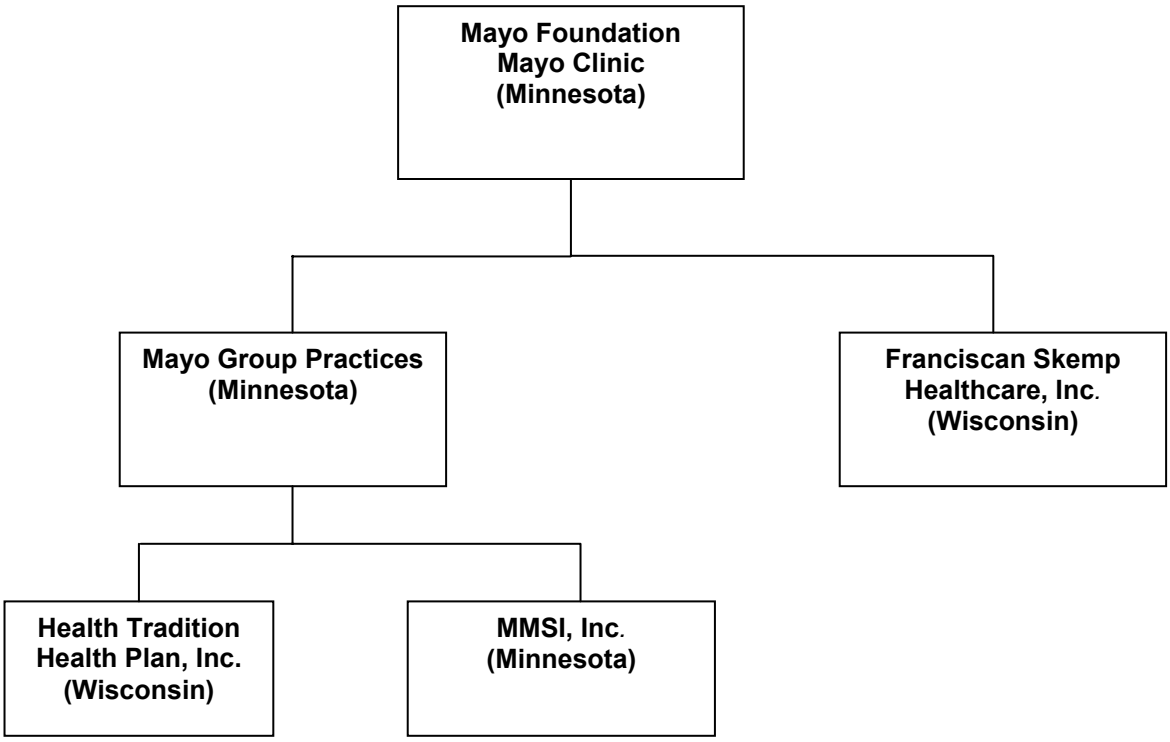
The HMO has met this requirement through its reinsurance contract, as discussed in the Reinsurance section of this report.

IV. AFFILIATED COMPANIES

The HMO is a member of a holding company system. Its ultimate parent is Mayo Foundation. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the HMO follows the organizational chart.

Holding Company Chart

As of December 31, 2002



Mayo Foundation

Mayo Foundation provides medical research, education, and service. The foundation's financial statements are audited on a consolidated basis. As of December 31, 2002, the Mayo Foundation audited financial statement reported assets of $5,696.4 million, liabilities of $3,381.2 million and net assets of $2,315.2 million. Operations for 2002 produced net income of $61.3 million on revenues of $4,425.1.

Mayo Group Practices

Mayo Group Practices provides health services. As of December 31, 2002, the company's financial statement reported assets of $609,135,851, liabilities of ($41,748,246), and capital and surplus of $650,884,097. Operations for 2002 produced net income of $41,826,097.

MMSI, Inc.

MMSI, Inc. (MMSI), provides services as a third party administrator of health plans. As of December 31, 2002, the company's financial statement reported assets of $12,271,006, liabilities of $3,630,742, and capital and surplus of $8,640,264. Operations for 2002 produced net income of $3,307,461 on revenues of $31,960,549.

Franciscan Skemp Healthcare, Inc.

Franciscan Skemp Healthcare, Inc. (FSHI) provides health care services. As of December 31, 2002, the company's financial statement reported assets of $139,764,640, liabilities of $73,990,112, and capital and surplus of $65,774,528. Operations for 2002 produced a net income of $9,602,703 on revenues of $329,392,186.

Affiliated Agreements

As mentioned in the Management & Control section of this report, the company has no employees. The company contracts with MMSI and FSHI to provide necessary services. The following is a description of the contracts:

- Administrative Services Agreement with MMSI - effective January 1, 1999, MMSI agrees to provide the company with the following services: underwriting, actuarial, board advisory, accounting/financial, marketing, claims processing, and data processing. Details concerning this agreement can be found in the Management & Control section of this report.

- Management Services Agreement with FSHI - FSHI agrees to provide to the company the following personnel services: medical director, administrative nurses, referral coordinators, and administrative assistant. Details concerning this agreement can be found in the Management & Control section of this report.

- Health Care Services Agreement with FSHI – This agreement arranges for the provision of healthcare services on a capitated basis. Details concerning this contract can be found in the History and Plan of Operations section of this report.

V. REINSURANCE AND CORPORATE INSURANCE

The HMO has reinsurance coverage under the contract outlined below:

Reinsurer:	Allianz Life Insurance Company of North America
Type:	Stop-Loss Reinsurance Agreement
Effective date:	January 1, 2002
Retention:	$100,000 per Covered Person per Agreement Period
Coverage:	Limits for Covered Acute Care Franciscan Hospital and Luther Hospital: Subject to the following Per Diems: $2,500 St. Mary's Hospital, Mayo Clinic, and Methodist Hospital: the lesser of 85% of billed or $3,500 per day Limits for Outpatient Care Mayo Clinic, St. Mary's Hospital, Methodist Hospital, Franciscan Hospital, and Luther Hospital: the lesser of 75% of billed or $1,500 per day Limits for all other facilities: the lesser of 75% of billed charges or $2,500 per day
Premium:	Commercial HMO: $2.93 per member per month Commercial POS: $3.13 per member per month

The reinsurance policy has an endorsement containing the following insolvency provisions:

Continuation of Coverage

1. Allianz will continue plan benefits for members who are confined on the date of plan insolvency in a hospital. Plan benefits for such services will begin on the date of plan insolvency and continue until the earlier of 365 days or the date of discharge.

2. Allianz will continue plan benefits for members who are confined on the date of plan insolvency in skilled nursing or rehabilitation facilities if receiving Covered Acute Care services. Plan benefits for such Covered Acute Care services will begin on the date of plan insolvency and continue until the earlier of 120 days, the date of discharge, or the date Covered Acute Care services cease.

3. Allianz will continue plan benefits for members (other than members subject to 1 or 2 above) from the date of plan insolvency through the contract period after plan insolvency for which premium had been paid to the plan, but for not more than 60 days, if such premium is paid prior to the date of plan insolvency.

4. For any members who are Medicaid or Title XVIII Medicare enrollees, 1, 2, and 3 above will apply, subject to the further limit that plan benefits will not extend beyond the date such member is entitled to coverage under the Title XVII Medicare provision or any other federal or state program.

Conversion of Coverage Provision

1. Allianz will issue conversion coverage to members, without evidence of insurability, other than members who are Medicaid or Title XVIII Medicare enrollees, who apply to Allianz for conversion coverage within 30 days of plan insolvency. The conversion coverage will be that which is customarily issued by Allianz at the then current rates and type available of conversion. Conversion Coverage Provision does not apply to the plan member, if at the time their coverage under the plan ends; they are a resident of any state where the provision of this option requires Allianz to enter the individual health market of the state.

In addition, the HMO is provided with corporate insurance coverage under the contracts listed below:

Type of Coverage	**Policy Limits**
Professional liability	$25,000,000
Fidelity bond coverage	500,000

The professional liability coverage was obtained through Aon Risk Services, Inc. of Minnesota and the fidelity bond coverage was obtained through Travelers Casualty and Surety Company.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the HMO as reported in the December 31, 2002, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the HMO for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

Health Tradition Health Plan, Inc.
Assets
As of December 31, 2002

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$ 5,203,914	$ 0	$ 5,203,914
Cash and short-term investments	7,980,483	0	7,980,483
Aggregate write-ins for invested assets	184,882	0	184,882
Accident and health premiums due and unpaid	261,212	47,730	213,482
Amounts recoverable from reinsurers	1,100,347	0	1,100,347
Investment income due and accrued	88,728	0	88,728
Federal and foreign income tax recoverable and interest thereon	309,561	190,906	118,655
Aggregate write-ins for other than invested assets	227,762	0	227,762
Total assets	$15,356,889	$238,636	$15,118,253

Health Tradition Health Plan, Inc.
Liabilities and Net Worth
As of December 31, 2002

Claims unpaid		$ 1,639,623
Premiums received in advance		1,442,125
General expenses due or accrued		332,156
Federal and foreign income tax payable and interest thereon		49,861
Amounts due to parent, subsidiaries and affiliates		5,602,191
Aggregate write-ins for other liabilities		26,204
Total liabilities		9,092,160
Common capital stock	$ 364,500	
Gross paid in and contributed surplus	3,965,482	
Surplus notes	575,779	
Unassigned funds (surplus)	1,120,332	
Total capital and surplus		6,026,093
Total liabilities, capital and surplus		$15,118,253

Health Tradition Health Plan, Inc.
Statement of Revenue and Expenses
For the Year 2002

Net premium income		$66,686,117
Aggregate write-ins for other health care related revenues		256,624
Total revenues		66,942,741
Medical and Hospital:		
Hospital/medical benefits	$42,345,361	
Other professional services	678,291	
Outside referrals	7,576,430	
Emergency room and out-of-area	1,022,842	
Prescription drugs	8,625,874	
Subtotal	60,248,798	
Less		
Net reinsurance recoveries	1,127,973	
Total medical and hospital	59,120,825	
Claims adjustment expenses	2,736,137	
General administrative expenses	5,067,889	
Total underwriting deductions		66,924,851
Net underwriting gain or (loss)		17,890
Net investment income earned		192,354
Aggregate write-ins for other income or expenses		(25,000)
Net income or (loss) before federal income taxes		185,244
Federal and foreign income taxes incurred		49,861
Net income (loss)		$ 135,383

Health Tradition Health Plan, Inc.
Capital and Surplus Account
As of December 31, 2002

Capital and surplus prior reporting year		$5,805,600
Net income or (loss)	$135,383	
Change in net deferred income tax	309,561	
Change in nonadmitted assets	(200,142)	
Aggregate write-ins for gains or (losses) in surplus	(24,309)	
Net change in capital and surplus		220,493
Capital and surplus end of reporting year		$6,026,093

Health Tradition Health Plan, Inc.
Statement of Cash Flows
As of December 31, 2002

Cash from Operations		
Premiums and revenues collected net of reinsurance		$68,402,389
Claims and claims adjustment expenses		60,035,015
General administrative expenses paid		5,260,040
Other underwriting income (expenses)		(328,401)
Cash from underwriting		2,778,933
Net investment income		314,756
Net cash from operations		3,093,689
Cash from Investments		
Proceeds from investments sold, matured or repaid:		
Bonds	$1,250,000	
Cost of investments acquired (long-term only):		
Bonds	3,750,938	
Net cash from investments		(2,500,938)
Net change in cash and short-term investments		592,752
Cash and short-term investments:		
Beginning of year		7,387,732
End of year		$ 7,980,484

Growth of Health Tradition Health Plan

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2002	$15,118,253	$9,092,160	$6,026,093	$66,686,117	$59,120,825	$185,244
2001	13,827,962	8,022,362	5,805,600	57,726,860	50,498,780	664,109
2000	12,117,314	6,996,320	5,120,996	43,742,054	37,677,589	903,646
1999	10,173,584	5,973,052	4,200,532	37,618,226	34,456,805	198,602

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2002	0.2%	88.6%	11.7%	-0.9%
2001	1.2	87.5	12.5	9.4
2000	2.1	86.1	13.3	16.4
1999	0.5	87.8	12.7	-5.2

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2002	25,988	324.78	3.61
2001	28,423	343.12	3.72
2000	28,173	371.81	3.58
1999	22,322	373.62	3.31

Per Member Per Month Information

	2002	2001	Percentage Change
Premiums:			
Commercial	225.15	196.97	14.3%
Medicare Select	114.08	97.24	17.3
Medicaid	124.00	116.42	6.5
Expenses:			
Hospital/medical benefits	125.39	111.57	12.4
Other professional services	2.01	1.76	14.2
Outside referrals	22.44	17.98	24.8
Emergency room and out-of-area	3.03	2.23	35.9
Prescription drugs	25.54	0.00	100.0
Other medical and hospital	0.00	24.21	-100.0
Less: Net reinsurance recoveries	3.34	3.79	-11.9
Total medical and hospital	175.07	153.95	13.7
Claims adjustment expenses	8.10	7.21	12.3
General administrative expenses	15.01	14.76	1.7
Total underwriting deductions	$198.17	$175.92	12.7

Reconciliation of Capital and Surplus per Examination

There were no adjustments to the HMO's capital and surplus as a result of this examination.

Following, is the one reclassification resulting from the examination:

	Debit	Credit
Short-Term Investments	$2,967,789	
Cash		$2,967,789

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were seven comments and recommendations in the previous examination report. Comments and recommendations contained in the previous examination report and actions taken by the HMO are as follows:

1. Conflict of Interest – It is again recommended that the company maintain and perform record of original Conflict of Interest Statements completed by its officer, directors, and key employees for third-party verification purpose.

   Action – Partial Compliance

2. Fidelity Coverage – It is recommended that the company increase its fidelity coverage to at least the minimum required by the NAIC Financial Condition Examiners Handbook.

   Action – Compliance

3. Disaster Recovery Plan – It is recommended that the company develop a disaster recovery plan that addresses the resumption of all operations for any type of disaster. The plan should identify the procedures to be performed, key individuals and vendors to contact, alternative locations, and required supplies. In addition, for the plan to continue to be relevant, it should be reviewed, updated, and tested annually.

   Action – Noncompliance

4. Annual Statement/Supplements – It is recommended that the company include all affiliated insurers (and all non-insurer affiliates with whom the company has transactions required to be reported in Schedule Y, Part 2), on Schedule Y, Part 1 Organization Chart in future annual statements, in accordance with the NAIC Annual Statement Instructions – HMO.

   Action – Compliance

5. Annual Statements/Supplements – It is recommended that the company include Medicare Select and Medicaid enrollees on the HMO Enrollment by Service Area worksheet in future annual statement supplements.

   Action – Compliance

6. Invested Assets – It is again recommended that the company execute a safekeeping or custodial agreement which includes the controls and safeguards as recommended by the NAIC.

   Action – Noncompliance

7. Surplus Note – It is recommended that the company receive approval from our office prior to any future interest payments, or principle repayments on the surplus note, in accordance with s. 611.33 (2) (d), Wis. Stat.

   Action – Compliance

Summary of Current Examination Results

Disaster Recovery Plan

The prior examination recommended that the company develop a disaster recovery plan. The company was able to provide documentation that work was done on developing a plan in 2002. The company indicated that due to resource issues, it is still in the beginning phases of developing a plan and the plan will not be complete until the end of 2004. The company did not, however, provide documentation to this office that there were problems in complying with this recommendation. It is again recommended that the company develop a disaster recovery plan that addresses the resumption of all operations for any type of disaster. The plan should identify the procedures to be performed, key individuals and vendors to contact, alternative locations, and required supplies. In addition, for the plan to continue to be relevant, it should be reviewed, updated, and tested annually.

Access Rights to System and Application Resources

Access is provided to the company by different avenues, including the Mayo Foundation Network and through Application controls. For the Mayo Foundation Network, it was indicated that there was no periodic review to ensure that all access was authorized. It was indicated that there were 60,000 employees and the task would not be simple. For the application access, the company indicated that an annual review is done to determine that all access to financially significant applications is authorized. The company did not retain evidence to document that this review was completed. It is recommended that the company establish a process to ensure that all active IDs are properly authorized for their access and that documentation be developed and maintained substantiating this process.

Invested Assets

Custodial Agreement

The prior examination recommended the company execute a safekeeping or custodial agreement with its custodian, which includes the controls and safeguards as recommended by the NAIC Financial Condition Examiners Handbook which are as follows:

- That the national bank, state bank, or trust company, as custodian is obligated to indemnify the insurance company for any insurance company's loss of securities in the custodian's custody, except that, unless domiciliary state law, regulation, or administrative action otherwise require a stricter standard the bank or trust company shall not be so obligated to the extent that such loss was caused by other than the negligence or dishonesty of the custodian; and

- That in the event of a loss of the securities for which the custodian is obligated to indemnify the insurance company, the securities shall be promptly replaced or the value of the securities and the value of any loss of rights or privileges resulting from said loss of securities shall be promptly replaced.

The company currently utilizes the services of one custodian, The Northern Trust Company, and has executed a custodial agreement with that company. Review of the Northern Trust Company Custodian Agreement revealed that the agreement does not contain the above safeguards recommended by the NAIC. It is again recommended that the company execute a safekeeping or custodial agreement which includes the controls and safeguards as recommended by the NAIC.

It was also discovered that the custodial account is in the name of Mayo Foundation Segregated Greater LaCrosse Health Plan while the custodial agreement is with Greater LaCrosse Health Plan. Both must be in the same name and must utilize the current, proper name of the company. It is recommended that the custodial account and agreement be in the proper name of the company pursuant to s. 610.23, Wis. Stat.

Repurchase Agreement

The company has a Master Sweep Repurchase Agreement between Mayo Health Plan, Mayo Health Plan Arizona, and Greater LaCrosse. The agreement is a pooling arrangement. These securities should be held in the company's name. The securities are not described in either the repurchase agreement or in the confirmation notice received by the company. The same amount of money is swept out at night and returned in the morning. Interest is earned on the securities. It is recommended that securities be held in the company's name in accordance with s. 610.23, Wis. Stat.

Repurchase agreements are considered short-term investments per the NAIC Annual Statement Instructions - Health. The company reported these amounts as cash on the annual statement. The year-end balance, which was included in cash, was $2,967,789. This amount

was reclassified by the examination to Short-Term Invesments. It is recommended the company properly report the funds utilized in its repurchase agreement as a short-term investment in accordance with the NAIC Annual Statement Instructions -Health and Accounting Practices and Procedures Manual.

For compulsory surplus purposes, the class limitation for investments in assets of a single issuer and its affiliates (10% of assets) is prescribed in s. 620.23 (2) (b), Wis. Stat. Pursuant to s. 620.22 (9), Wis. Stat. (the "basket" clause), the company may include investments not specifically prohibited by statue, to the extent of not more than 5% of the first $500,000,000 of the insurer's assets plus 10% of the insurer's assets exceeding $500,000,000 for compulsory and security surplus calculations. Section 620.21, Wis. Stat., states that the amount of the investment exceeding the limitations cannot be counted toward satisfying the compulsory and security surplus requirement. The examiners did not make an adjustment to the company's compulsory surplus calculation because the balance attributed to the repurchase activity was not determined due pooling of funds within the repurchase activity. The company is being given an opportunity to remedy this matter. It is recommended that the company develop a plan that outlines how the company will comply with compulsory surplus requirements for future filings and file the plan with this office within sixty days of adoption of this report.

Conflict of Interest Statements

The prior examination recommended the company maintain a record of original Conflict of Interest Statements completed by its officer, directors, and key employees for third-party verification purposes. The examiners determined that, in one instance, the company was unable to locate an individual's 2000 conflict of interest statement. It is again recommended that the company maintain a record of original Conflict of Interest Statements completed by its officers, directors, and key employees for third-party verification purposes.

Financial Reporting

The examination disclosed the following errors on the company's annual statement:

- The company reported the incorrect actual cost for some of its bonds. The error was immaterial; however the actual cost of bonds should be correctly reported in future annual statements.

- The company answered "Not applicable" to section 5 - Investments - Part E - Repurchase Agreements in the Notes to the Financial Statement. The examination determined that the HMO does have a repurchase agreement.

- The company included the following disclosure in the Notes to the Financial Statement: "Reinsurance premiums are netted against reinsurance recoveries and are recognized ratably over the period of reinsurance coverage." This disclosure only applies to GAAP and was included in the statutory statement in error.

It is recommended the company properly fill out the annual statement in accordance with the NAIC Annual Statement Instructions - Health.

Unclaimed Property

The review of the bank reconciliations revealed that the company had not been setting up a liability for long checks that have been outstanding for a long period of time, but instead maintained the checks on the listing of outstanding checks until they are cashed, if ever. It is recommended the company comply with ch. 177, Wis. Stat., as regards unclaimed funds, and that a liability for unclaimed funds be established in future statutory annual statements to account for all checks outstanding for over one year.

Internal Controls

The company uses a third party to administer its Medicaid business which represents about 12% of the company's total business. The examiners requested a SAS 70, an independent review of the control objectives and control activities, to place reliance on the UCare's control environment for the purposes of the examination. The company indicated that a SAS 70 was not available. It is recommended that the company require UCare to provide a SAS 70 report or acceptable alternative on the control activities relevant to the administration of the Medicaid business.

Security Violations

The examiners noted that the company does not have a formal procedure for reviewing security violations. The company should require that security violations related to unauthorized access to its data be subject to formal security violation review procedures.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The HMO's calculation as of December 31, 2002, as modified for examination adjustments is as follows:

Assets	$15,118,253	
Less:		
Special deposit	184,882	
Liabilities	9,092,160	
Examination adjustments	0	
Total		$5,841,211
Net premium earned (HMO business)	66,143,112	
Compulsory factor	3%	
HMO business compulsory surplus	1,984,293	
Net premium earned (Incidental indemnity)	543,005	
Compulsory factor	10%	
Incidental indemnity premium compulsory surplus	54,300	
Compulsory surplus		2,038,593
Compulsory excess		$3,802,618

VIII. CONCLUSION

Health Tradition Health Plan, Inc. (HTHP) is a for-profit insurer offering a group model HMO product that serves seven counties throughout Wisconsin. The company was incorporated on January 16, 1986, and commenced business on April 28, 1986. HTHP is a wholly owned subsidiary of Mayo Group Practices, a Minnesota Corporation.

The company provides two group insurance products (Premier and Premier Plus), and one individual Medicare Select insurance product (65 Plus). The company also derives a percentage of its revenues (approximately 12% in 2002) from its participation in Wisconsin's Medicaid/BadgerCare program, through a contract with the Wisconsin Department of Health and Family Services.

The company's operating results have generally been profitable, with positive net income posted in 3 of the last 4 years. In addition, net premiums earned have increased by 75.8% over the four-year period since the prior examination.

The examination noted deviations from Wisconsin Statutes and NAIC guidelines. Recommendations have been made to bring the company into compliance with those statutes and guidelines.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 23 - Disaster Recovery Plan—It is again recommended that the company develop a disaster recovery plan that addresses the resumption of all operations for any type of disaster.

2. Page 23 - Access Rights to System and Application Resources—It is recommended that the company establish a process to ensure that all active IDs are properly authorized for their access and that documentation be developed and maintained substantiating this process.

3. Page 24 - Invested Assets—It is again recommended that the company execute a safekeeping or custodial agreement which includes the controls and safeguards as recommended by the NAIC.

4. Page 24 - Invested Assets—It is recommended that the custodial account and agreement be in the proper name of the company pursuant to s. 610.23, Wis. Stat.

5. Page 24 - Invested Assets—It is recommended that securities be held in the company's name in accordance with s. 610.23, Wis. Stat.

6. Page 25 - Invested Assets—It is recommended the company properly report the funds utilized in its repurchase agreement as a short-term investment in accordance with the NAIC Annual Statement Instructions -Health and Accounting Practices and Procedures Manual.

7. Page 25 - Invested Assets—It is recommended that the company develop a plan that outlines how the company will comply with compulsory surplus requirements for future filings and file the plan with this office within sixty days of adoption of this report.

8. Page 25 - Conflict of Interest Statements—It is again recommended that the company maintain a record of original Conflict of Interest Statements completed by its officers, directors, and key employees for third-party verification purposes.

9. Page 26 - Financial Reporting—It is recommended the company properly fill out the annual statement in accordance with the NAIC Annual Statement Instructions - Health.

10. Page 26 - Unclaimed Property—It is recommended the company comply with ch. 177, Wis. Stat., as regards unclaimed funds, and that a liability for unclaimed funds be established in future statutory annual statements to account for all checks outstanding for over one year.

11. Page 26 – Internal Controls— It is recommended that the company require UCare to provide a SAS 70 report or acceptable alternative on the control activities relevant to the administration of the Medicaid business.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the HMO is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, state of Wisconsin, participated in the examination:

Name	Title
Lori Cretney	Insurance Examiner
Randy Milquet	Insurance Examiner-Advanced

Respectfully submitted,

Bridgot A. Quandt
Examiner-in-Charge